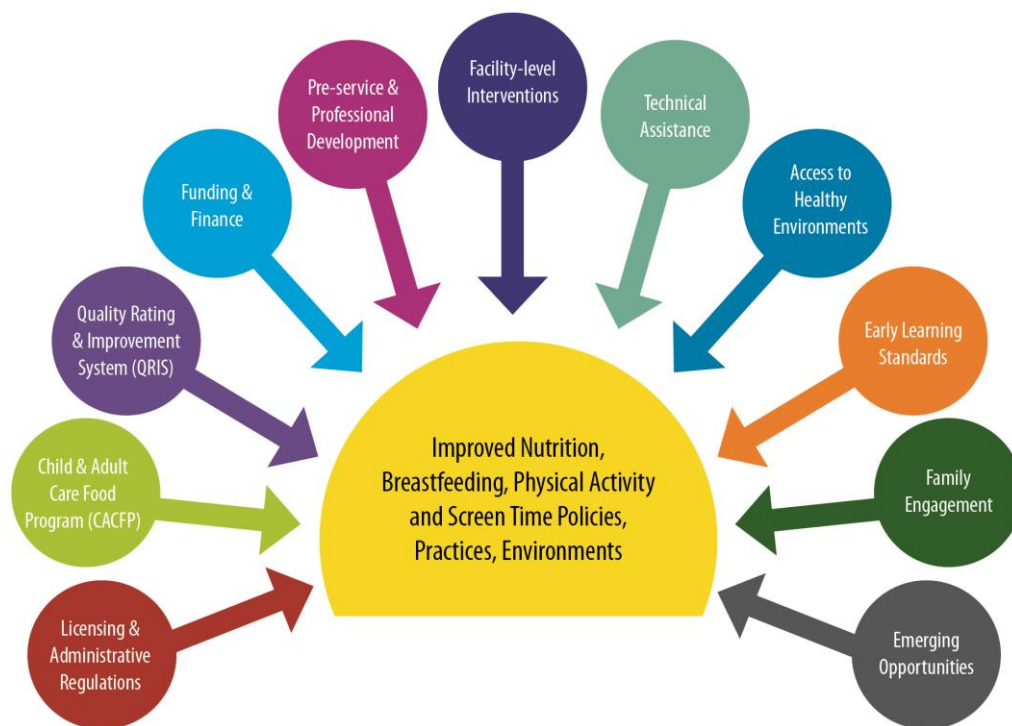


Spectrum of Opportunities for Obesity Prevention in the Early Care and Education Setting (ECE) CDC Technical Assistance Briefing Document

This document outlines a ‘Spectrum of Opportunities’ (see Figure 1) exists by which states, and to some extent communities, can support ECE facilities in their jurisdictions to achieve recommended standards and best practices for obesity prevention. Each opportunity, described below, represents a unique avenue by which states or communities have worked successfully to change the ECE environment to improve nutrition, breastfeeding support, physical activity and reduce screen time in ECE facilities. Not all opportunities need to be pursued successfully in each state to achieve impact; however, it is likely that multiple opportunities pursued as part of a coordinated approach will be most effective at achieving desired goals. Some opportunities would disproportionately impact children from low-income families and, thus, are particularly relevant for addressing income-related health disparities. Successful ECE efforts require strong partnerships with diverse stakeholders and careful consideration of multiple factors that determine the viability of any opportunity at a given point in time, including but not limited to costs (resource, personnel), stakeholder support, available resources, reach, timing cycles, and ECE provider needs.

-Figure 1-

**Spectrum of Opportunities for Obesity Prevention
in the Early Care and Education Setting**



Licensing and Administrative Regulations—Licensing is permission from the state to operate an ECE facility. All programs and providers (with some exceptions) are required by law to meet state-specific minimum standards of care. Regulations and enforcement standards vary considerably by state and, sometimes, by municipalities. Obesity prevention strategies can be incorporated into licensing and administrative regulations in several ways, including:

- 1) Requiring that facilities meet specific nutrition, breastfeeding, physical activity, and screen time standards (e.g., setting a minimum number of minutes per day of physical activity);
- 2) Incentivizing facilities to meet standards voluntarily through a reduction in licensing fees;
- 3) Requiring ECE providers to obtain training, continuing education or certification in obesity prevention, including nutrition, breastfeeding, physical activity, and screen time;
- 4) Incorporating obesity prevention messages and standards into coursework, training, and education requirements for ECE providers; and
- 5) Requiring that all facilities meet the Child and Adult Care Food Program standards regardless of participation in the program.

Child and Adult Care Food Program (CACFP)—CACFP is a federal nutrition assistance entitlement program that provides reimbursement for meals and snacks served to more than 3.2 million children. CACFP regulates meal patterns and portion sizes, provides nutrition education, and offers sample menus and training in meal planning and preparation to help ECE providers comply with nutrition standards. Most legally operating ECE facilities, including centers and family-homes, are eligible to participate in CACFP. States can use CACFP to help promote healthy eating and decrease obesity in young children in ECE by:

- 1) Providing CACFP training and technical assistance focused on nutrition, breastfeeding, physical activity, and screen time education for children, teachers, and parents;
- 2) Enhancing state CACFP standards to align with other national nutrition guidelines such as the U.S. Dietary Guidelines for Americans if they do not already; and
- 3) Providing information on how to increase CACFP participation among facilities.

Quality Rating and Improvement Systems (QRIS)—A QRIS is a systemic approach to assess, communicate, and improve the level of quality in early childhood and school-age care and education programs. Through QRIS, states define what constitutes a higher quality of care based on designated criteria and use a rating system with a recognizable and understandable symbol to communicate to the public how well participating ECE facilities meet these criteria. QRIS is often linked to child care subsidy reimbursement rates. Additionally, QRIS uses licensing and administrative regulations as a baseline to define what constitutes improved quality. QRIS is often linked to enhanced training, professional development, qualifications, and program accreditation. Obesity prevention strategies can be incorporated into QRIS by:

- 1) Designating specific nutrition, breastfeeding, physical activity, or screen time standards needed to reach higher quality ratings (e.g. setting a minimum number of minutes per day of physical activity above what is required in state licensing regulations);



- 2) Requiring participating providers to conduct a systematic assessment of their policies and practices related to obesity prevention, such as the assessment included in the Nutrition and Physical Activity Self-Assessment for Child Care (NAP SACC) intervention;
- 3) Including obesity prevention-specific technical assistance activities in the set of materials and resources that programs participating in QRIS receive; and
- 4) Incorporating obesity prevention information into coursework training and education requirements for child care providers.

Funding and Finance—States, through their general funds, invest in ECE over and above the allocations they receive from several federal government programs [e.g. Child Care and Development Fund (CCDF), Temporary Assistance for Needy Families (TANF), Head Start, Social Service Block Grants (SSBG), CACFP, and Maternal and Child Health Block Grants (MCHB)]. As of FY 2008, states were appropriating \$13.6 billion of state funds to ECE for services such as child care, pre-K, home visiting, and other early learning strategies. In many states, the department of education and local school districts provide funds to support preschool and afterschool child care providers and expand Head Start programs. In some states, the legislature has authorized state funds to develop QRIS for ECE.

States can also use their authority to set standards for the CCDF and SSBG to enhance requirements for healthy eating, breastfeeding support, physical activity, and reduced screen time. They can also require parent education and engagement in obesity prevention efforts. States can require or incentivize ECE providers that receive TANF/CCDF subsidies to implement obesity prevention policies and programs as a condition for participation. Additionally, states can use their MCHBG to provide training and technical assistance for ECE providers and to help implement various obesity prevention interventions and some have used Supplemental Nutrition Assistance Program Education funding for obesity prevention efforts targeting ECE.

Pre-service and Professional Development—Pre-service training, also known as certification in some states, refers to a program or series of trainings required for adults to become ECE providers and work in a state-governed ECE facility. Professional development refers to ongoing professional training for current ECE providers. States typically specify how often and how many continuing education credits must be earned and the content areas for training in their licensing and administrative regulations. Many states specify a set of core knowledge and competencies that define what effective ECE providers should understand and be able to do in order to be effective in their role. A few ways to incorporate obesity prevention strategies into ECE provider pre-service and professional development training for ECE providers include:

- 1) Ensuring that educators of ECE professionals are trained on nutrition, breastfeeding, physical activity, and screen time and that early childhood degree programs include this material in required coursework;
- 2) Offering optional coursework in obesity prevention for those students interested in learning more about adult and child health;
- 3) Requiring that state certification and continuing education programs incorporate nutrition, breastfeeding, physical activity, and screen time messages; and



- 4) Offering optional training in obesity prevention for certification and continuing education programs for those providers interested in going beyond minimum requirements. This can be incorporated as part of a state QRIS or special designation for providers and facilities.

Facility-level Interventions—Facility-level interventions are any programs or initiatives that encompass a defined set of activities that take place directly within ECE facilities. They may seek to alter policies and practices within the facility or to support behavior change in children directly. Interventions may specifically target one aspect of obesity prevention, such as breastfeeding support, or may be comprehensive to include nutrition, breastfeeding, physical activity, and screen time. Interventions can entail a single component, such as a curriculum, or have multiple components that are mutually reinforcing. Numerous facility-level interventions, especially curricula, are available to help promote nutrition, breastfeeding, physical activity, and limit screen time in young children in ECE including, to name a few: Color Me Healthy; Grow it, Try it, Like it; I am Moving, I am Learning; the Nutrition and Physical Activity Self-Assessment for Child Care; Eat Well, Play Hard in Child Care; and Let's Move! Child Care. Facility-level interventions may differ fundamentally in their approach, but when used together, can complement one another and provide a more comprehensive approach to childhood obesity prevention.

Technical Assistance—Within the context of ECE, technical assistance is the provision of expert advice and guidance to ECE providers to improve the quality of care provided by changing practices. It typically encompasses observation, assessments, support, and monitoring. Each state has a child care resource and referral network (or agency) through which ECE facilitator can access technical assistance providers. Technical assistance may also be provided by staff from the state licensing agency and the Child and Adult Care Food Program as well as by child care health consultants, Cooperative Extension agents, physicians, county and state nutritionists, and health department nurses. Nutrition professionals can provide technical assistance to ECE programs on menu planning, nutritional assessment of meals and snacks, training for foodservice personnel, and nutrition education for ECE providers, children, and families. Experts in physical activity can help ECE providers promote energy expenditure in young children through active play and reduced screen time. Lactation consultants can help providers optimize the level of support they provide to breastfeeding mothers.

Access to Healthy Environments—Access to nutritious foods and space for active play is essential if ECE providers are to comply with enhanced regulations, QRIS, and facility-level interventions that support obesity prevention efforts. States and communities can promote access to healthy environments for children in ECE settings and their families in a number of ways, including through joint use agreements, farm to preschool initiatives, and centralized kitchens that provide affordable, nutritious meals to ECE facilities in a defined geographical area.

Early Learning Standards—Nearly every state has adopted standards for ECE to provide a framework on content areas that must be taught and assessed in young children birth to 5 years of age. State ECE agencies or state departments of education typically oversee curricula and educational programs provided to ECE facilities, especially state-administered ECE programs, to prepare young children for entry to school. As state agencies create new or revise existing early learning standards, opportunities exist to emphasize nutrition, breastfeeding, physical activity, and screen time.



Family Engagement—Family engagement is not so much a distinct mechanism for achieving obesity prevention strategies in ECE but is, rather, a critical component for implementation of changes carried out through the other opportunities. Family engagement refers to the active collaboration and commitment between families and their ECE providers. Families are essential partners when it comes to promoting the health of children, as they have a great deal of influence over the food and physical activity choices available to children and are primary role models for children’s behavior—especially for children younger than 5 years of age. Strong family engagement will help ensure successful implementation of policy and practice changes to promote obesity prevention in ECE pursued through the spectrum of opportunities and can produce ripple effects with respect to improving home environments and families’ behaviors.

Emerging Opportunities – The opportunities featured on the spectrum for achieving practice and policy change are shared by most states. Consider whether additional opportunities exist that are unique to your state.

RESOURCES

National Guidelines for Obesity Prevention Standards in ECE:

<http://www.nrckids.org/SPINOFF/PCO/PreventingChildhoodObesity2nd.pdf>

CDC’s Weight of the Nation Obesity Prevention in ECE Policy Review:

http://www.cdc.gov/obesity/downloads/Early-Care-and-Education-Policy-Review-FINAL_web508.pdf

National Review of State Licensing Regulations Alignment with National Guidelines for Obesity Prevention:

www.nrckids.org/ASHW/ASHW%202011-Final-8-1.pdf

State Efforts to Address Obesity Prevention in Child Care Quality Rating and Improvement Systems

http://www.altarum.org/files/pub_resources/QRIS-Report-22Feb12-FIN.pdf

Several Intervention Strategies for Obesity Prevention Targeting the ECE setting are posted on the Center-TRT website: http://centertrt.org/?p=interventions_strategies_overview

Child and Adult Care Food Program Wellness Toolkit

<http://frac.org/federal-foodnutrition-programs/child-and-adult-care-program/child-care-wellness-plans-and-policies/>

Let’s Move! Child Care: www.healthykidshealthyfuture.org

